Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

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IN REPLY REFER TO
FILE NO: 933 0195
USPS Priority Mail

June 18, 2004

FINAL REPORT

Dr. David Kutner, DMD, President
AMERICAN HEALTHGUARD CORPORATION
30 East Santa Clara, Suite D
Arcadia, CA 91006

ROUTINE EXAMINATION OF AMERICAN HEALTHGUARD CORPORATION

Dear Dr. Kutner,

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of American Healthguard Corporation (the "Plan") for the quarter ended November 30, 2003, conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on March 25, 2004. The Department accepted the Plan's response electronically on June 17, 2004.[2]

This Final Report includes a description of the compliance efforts included in the Plan's June 17, 2004 response, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies (hardcopy and electronically) of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

[2] The Department received a hard copy of the Plan's response on May 18, 2004

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its June 17, 2004 response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response of June 17, 2004 did not fully resolve some of the deficiencies raised in the Preliminary Report issued by the Department on March 25, 2004. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained in the attached Final Report, within thirty (30) days after receipt of the report.

Please send a hardcopy of your response directly to the undersigned. In addition, please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal (<https://wp.dmhc.ca.gov/efile>) under **Report/Other**, subfolder RUXAM and barcode RX004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is specifically for the response to this final report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 or email at arodriguez@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter

If there are any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Mark Wright, Chief, Division of Financial Oversight
Galal Gado, Examiner, Division of Financial Oversight
Edward Carrillo, Counsel, Division of Licensing
Patricia Mazzeo, Examiner, Division of Financial Oversight
Chief Audit Section - Department of Health Services

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

AMERICAN HEALTHGUARD CORPORATION

FILE NUMBER: 933 0195

DATE OF FINAL REPORT: JUNE 18, 2004

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: GALAL GADO

FINANCIAL EXAMINERS:

MARIA MARQUEZ

MARYAM TAHIRI

BACKGROUND INFORMATION FOR
AMERICAN HEALTHGUARD CORPORATION

Date Plan Licensed:	September 28, 1984
Organizational Structure:	The Plan has one shareholder, Dr. David Kutner, DMD. He is the sole owner. The Plan has contracted with established members of the dental profession to provide health plan members with quality dental care and treatment.
Type of Plan:	Specialized dental plan.
Provider Network:	Dr. Kutner has three affiliated dental offices. The Plan also arranges for the provision of dental care services through contracted providers and specialists. Providers are paid on a capitated basis. Specialists are paid at a discounted fee-for-service rate.
Plan Enrollment:	21,124
Service Area:	Southern California
Date of Last Public Report of a Non-Routine Examination:	June 6, 2003

FINAL REPORT OF A ROUTINE EXAMINATION OF AMERICAN HEALTHGUARD CORPORATION

This is the Final Report of a routine examination of the fiscal and administrative affairs of American Healthguard Corporation (the "Plan") for the quarter ended November 30, 2003 conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on March 25, 2004. The Department accepted the Plan's response electronically on June 17, 2004.[2]

This Final Report includes a description of the compliance efforts included in the Plan's June 17, 2004 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited examination of the financial report filed with the Department for the quarter ended November 30, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

Our findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Calculation of Administrative Costs
Section IV.	Administrative Capacity
Section V.	Compliance Issues
Section VI.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contain in this report, within thirty (30) days of receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

[2] The Department received a hard copy of the Plan's response on May 18, 2004

SECTION I. FINANCIAL REPORT

A. BALANCE SHEET – AS OF NOVEMBER 30, 2003

	Reported per F/S @ 11/30/03	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 11/30/03
CURRENT ASSETS				
Cash	$ 413,150			$ 413,150
Premiums Receivables – Net	29,866			29,866
Prepaid Expenses	52,250			52,250
TOTAL CURRENT ASSETS	$ 495,266			$ 495,266
OTHER ASSETS				
Restricted Assets	$ 50,000			$ 50,000
Interest Receivable	33,750			33,750
Note Receivable - Shareholder	125,000			125,000
Aggregate Write-Ins for Other Assets	3,985			3,985
TOTAL OTHER ASSETS	$ 212,735			$ 212,735
PROPERTY AND EQUIPMENT				
Land, Building and Improvements	$ 5,155			$ 5,155
Software Development Costs	117,236			117,236
TOTAL PROPERTY AND EQUIPMENT	$ 122,391			$ 122,391
TOTAL ASSETS	$ 830,392			$ 830,392

BALANCE SHEET
AS OF NOVEMBER 30, 2003 (continued from previous page)

	Reported per F/S @ 11/30/03	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 11/30/03
CURRENT LIABILITIES				
Trade Accounts Payable	$ 26,718			$ 26,718
Capitation Payable	31,715			31,715
Incurred But Not Reported Claims	7,000			7,000
Unearned Premiums	294,996			294,996
Loans and Notes Payable - Shareholders	12,050			12,050
Aggregate Write-Ins - Current Liabilities	44,666			44,666
TOTAL CURRENT LIABILITIES	$ 417,145			$ 417,145
OTHER LIABILITIES				
Loans and Notes Payable – Long Term (Subordinated)	$ 218,600			$ 218,600
Interest Payable (Subordinated)	128,667			128,667
TOTAL OTHER LIABILITIES	$ 347,267			$ 347,267
TOTAL LIABILITIES	$ 764,412			$ 764,412
NET WORTH				
Capital	$ 4,000			$ 4,000
Paid in Surplus	20,000			20,000
Retained Earnings	41,980			41,980
TOTAL NET WORTH	$ 65,980			$ 65,980
TOTAL LIABILITIES & NET WORTH	$ 830,392			$ 830,392

B. INCOME STATEMENT

STATEMENT OF INCOME AND EXPENSES
FOR THE QUARTER ENDING NOVEMBER 30, 2003

	Reported per F/S @ 11/30/03	Examination Adjustments Debit		Examination Adjustments Credit		Examination Balance @ 11/30/03
REVENUES						
Premium	$ 159,717					$ 159,717
Title XIX – Medicaid	89,255					89,255
Interest	4,658					4,658
TOTAL REVENUE	$ 253,630					$ 253,630
MEDICAL AND HOSPITAL EXPENSES						
Primary Professional Services – Capitated	$ 86,656					$ 86,656
Other Medical Professional Services – Non Capitated	4,699					4,699
TOTAL MEDICAL & HOSPITAL	$ 91,355					$ 91,355
ADMINISTRATION						
Compensation	$ 67,636					$ 67,636
Interest Expense	5,044					5,044
Occupancy, Depreciation and Amortization	20,933					20,933
Marketing	0 R-1	7,965				7,965
Aggregate Write-Ins for Other Expenses	69,978		R-1	7,965		62,013
TOTAL ADMINISTRATION	$ 163,591	$ 7,965		$ 7,965		$ 163,591
TOTAL EXPENSES	$ 254,946					$ 254,946
INCOME (LOSS)	$ (1,316)					$ (1,316)
Provision for Taxes	800					800
NET INCOME (LOSS)	$ (2,116)	$ 7,965		$ 7,965		$ (2,116)

C. RECLASSIFYING JOURNAL ENTRY

RJE No.	ACCOUNT NAME	DR	CR
R-1	Marketing Expenses Aggregate Write-Ins for Other Expenses *To properly classify marketing expenses*	$7,965	$7,965

No response was required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth Per Examination as of November 30, 2003 (From Section I.A)	$ 65,980
Less: Receivables from Shareholder	<158,750>
Add: Subordinated Debt	218,600
Add: Subordinated Interest on Debt	128,667
Tangible Net Equity	$ 254,497
REQUIRED TNE as of November 30, 2003	50,000
Excess TNE as of November 30, 2003	$ 204,497

As of November 30, 2003, the Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76.

No response was required to this Section.

SECTION III. CALCULATION OF ADMINISTRATIVE COSTS

Rule 1300.78 (b) requires that administrative costs incurred by the plan must be reasonable and necessary. This Rule states that should administrative costs of a plan that has been in operation for five years or more exceed 15% of subscriber revenue then such plan may be called upon to demonstrate that such costs are not excessive.

The Plan's administrative cost ratio exceed 15% of subscriber revenue as follows:

Revenues from subscribers and enrollees per examination (from Section I.B.)	$248,972
Administrative Costs per examination (from Section I. B.)	$163,591
Administrative Cost percentage as of November 30, 2003	65.7%

The Plan was required to demonstrate that such administrative costs were not excessive within

the meaning of Section 1378 and were justified under the circumstances; and/or provide a written statement as to the procedures or actions instituted to reduce administrative costs that are proving effective.

The Plan responded that its administrative costs are reasonable and necessary given its size, stage of development and other circumstances. Furthermore, the Plan believes that the thresholds used to judge administrative cost are not designed for specialized health care service plans.

The Plan stated that its administrative cost ratios are a function of not only the amount of administrative costs, but also the revenue generated as a result of those costs. The Plan feels that specialized Plans have a high level of fixed costs because of the administrative capacity standards imposed by the Knox-Keene requirements. The Plan believe this is especially true for specialized health care service plan because they are required to have the same system and staffing as full service plans, but their premiums are less than one tenth that of the full service plans. This results in specialized health care service plans needing much higher levels of enrollment to maximize the efficiency of their administrative costs and reduce the ratio to within the thresholds set forth in Rule 1300.78.

The Plan submitted a comparison of its administrative expenses against eleven of the licensed Plans that were similar in function and operation as American Healthguard for the period ending December 2003 and found that the average administrative expenses across the plans was 42.55%. The lowest being a 16% administrative cost on $26,631,613.00 annual revenue and the highest being 110% administrative cost on $678,640 annual revenue. The Plan's comparison noted that none of the eleven plans reported an administrative cost ratio of 15% or less and only four of the eleven showed an administrative cost ratio of 25% or less.

The Plan's comparison concluded that the administrative cost ratios of the plans are directly tied to the level of the plan's enrollment. Thus, the Plan believes that its high administrative cost ratio is not a function of its administrative costs being too high, but its enrollment being low.

The Plan also added that the D & O, Malpractice premiums increased from just over $15,000 a year in calendar years 2001 to 2002, to over $40,000 for 2003 to 2004. The Plan stated that this increase accounts for almost 15% of the overall increase in administrative costs from calendar year 2001 to 2003. Additionally, as a result of both the response to the previous medical and financial surveys that required the Plan to increase staffing, combined with recent legislation, have imposed significant administrative burden that have added to the Plan's administrative costs.

The Plan further stated that based upon the overall industry averages, it is highly unlikely that the Plan will meet the Rule 1300.78 thresholds for administrative cost ratios anytime in the near future, especially as it continues to grow. Thus, the Plan states that this issue will certainly be raised as a repeat deficiency in the next examination.

The Plan's response adequately justified its administrative costs.

SECTION IV. ADMINISTRATIVE CAPACITY

Section 1367 (g) and Rule 1300.67.3 require every plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. This includes sufficient staffing in administrative services and written procedures for effective controls that result in the effective conduct of the plan's business.

Although, the Plan has made substantial improvements since our prior examination by hiring additional staffing and establishing written procedures for effective controls, the following deficiencies in administrative capacity were noted in our examination:

- The Plan did not maintain adequate books and records.

- The Plan incorrectly reported information in its quarterly financial statements filed with the Department.

The Plan was required to state the actions taken to ensure that its books and records are maintained in compliance with the financial requirements of the Act and Rules. The Plan was also required to identify the management position responsible for ongoing compliance.

The Plan responded that it relied on the experience and representations made by its financial staff to prepare bank records in accordance with the Act and Rules. With the help and guidance from the Department, the Plan now understands the inaccuracies of the books and records and has made corrective adjustments. As a result, the Plan is making organizational changes to its financial staff and will train all the new staff in the correct procedures, in order to maintain adequate books and records and insure ongoing compliance. In addition, the Plan has developed a checklist for reviewing the bank reconciliations to insure that they are maintained adequately. Furthermore, the Plan's CPA has been made aware of the inaccuracies and will review the bank reconciliation on a quarterly basis to provide ongoing compliance effort.

The Department finds that the compliance efforts by the Plan are not fully responsive to the deficiencies cited and the corrective actions required by the Department. The Plan responded that its CPA will review the bank reconciliation to provide ongoing compliance. However, the Plan needs to identify the management position that will be responsible for monitoring the adequacy of the CPA's reviews.

SECTION V. COMPLIANCE ISSUES

A. STATUS OF CLAIMS

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Our examination disclosed that the Plan has failed to implement procedures that comply with Rule 1300.77.4 in that all received claims are not stamped with the received date.

Examples of claims without a date received stamp are claim numbers: 1009101502, 2236040903, 5508051303, 6721090203, 4394100802, 4388emerg, and 5000091903.

The Plan was required to submit the revised policy and procedures implemented to resolve the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan responded that it has made an investment in a "Claims Management System" and has revised its policies for the date stamping and handling of claims. The new Claims system will automate most of the manual process the Plan currently uses. The Plan submitted its new policies with its response and identified the Chief Operation Officer and Dental Director as the management positions responsible for compliance.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective action required by the Department.

B. CLAIMS REIMBURSEMENT

Section 1371 and Section 1371.35 requires a health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim.

1. LATE PAYMENT AND LATE DENIAL OF CLAIMS

The examination included a review of 10 paid claims out of 59 claims paid since July 2001.

The number and type of claims are summarized below:

CLAIM TYPE	NUMBER OF CLAIMS REVIEWED
Paid non-emergency	5
Paid emergency	5

The Plan failed to pay claims within 30 working days of receipt as required by Section 1371 and Section 1371.35 in 8 of the 10 paid claims reviewed, representing13.6% of the total paid claims since July 2001. Claims not paid within 30 working days are shown below:

CLAIM NO.	DATE RECEIVED	DATE PAID	DAYS LATE
1009101502	01/16/02	10/11/02	224
678062602	08/28/02	10/18/02	7
5508051303	06/17/03	08/04/03	4

CLAIM NO.	DATE RECEIVED	DATE PAID	DAYS LATE
4725060303	08/18/03	11/14/03	44
6721090203	09/29/03	11/14/03	4
4388emerg	09/10/03	11/14/03	21
4388emerg	09/22/03	11/14/03	9
5000091903	09/29/03	11/14/03	2

The Plan was required to submit a Corrective Action Plan ("CAP") that outlines in detail how the Plan intends to correct this problem. The CAP was to include the policies and procedures implemented to ensure that claims are paid or denied timely. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that it is in the process of completely restructuring the claims management system. The Plan submitted a CAP showing some of the preliminary actions and changes that it is making. The Plan stated that its Claims clerk will review all the claims paid since 2001 on a manual basis to verify that they have been paid with the required interest and penalty amounts required. The Plan will have this completed by June 1st, 2004. The Plan identified the COO and Dental Director as the management positions responsible for overseeing the corrective action.

The Department finds that the compliance efforts by the Plan are not fully responsive to the deficiencies cited and the corrective actions required by the Department. The Plan still needs to provide evidence of the corrective actions required in items 2 and 3 below.

2. INTEREST ON LATE CLAIMS

Section 1371 requires that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period. This Section also requires that all interest that has accrued shall be automatically paid. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars.

Section 1371.35 (b), which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 30 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 30 working day period.

5 of the 10 claims reviewed during the examination were late paid claims in which the Plan failed to pay the correct amount of interest and penalties required by Section 1371 and Section 1371.35.

A sample of late paid claims in which incorrect interest or penalties were paid is shown below:

CLAIM NO.	DAYS LATE	INTEREST PAID	INTEREST DUE	ADDITIONAL AMOUNT DUE
1009101502	224	None	$141.30	$141.30
6721090203	2	$10.13	$15.00	$4.87
4388emerg	21	$10.68	$15.00	$4.32
4388emerg	9	$11.73	$15.00	$3.27
5000091903	2	$11.50	$15.00	$3.50

The Plan was required to submit a Corrective Action Plan ("CAP") that identifies all claims paid late, since it started paying claims in 2001, which have not been paid with the required interest and penalty amounts. Furthermore, the Plan was required to submit evidence that the correct amount of interest and $10 fee, if applicable, were paid for all claims identified.

The CAP was to include the policies and procedures implemented to ensure that late claim payments will include interest and penalties. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan submitted a CAP showing some of the preliminary actions and changes that it is making. The Plan stated that its Claims clerk will review all the claims paid since 2001 on a manual basis to verify that they have been paid with the required interest and penalty amounts required. The Plan will have this completed by June 1st, 2004. The Plan identified the COO and Dental Director as the management positions responsible for seeing the corrective action.

The Department finds that the compliance efforts by the Plan are not fully responsive to the deficiency cited and the corrective actions required by the Department. The Plan indicated that its identification of late claims will be completed by June 1, 2004. Therefore, the Plan will need to submit evidence with its response to this Final Report that the correct amount of interest and $10 fee, if applicable, were paid for all late claims identified.

3. ACCURACY OF CLAIM PAYMENTS TO CONTRACTED PROVIDERS

Our examination noted that the Plan did not accurately pay 8 out of 10 claims reviewed in accordance with the contract between the Plan and the specialist.

The list of claims paid incorrectly is as follows:

CLAIM NO.	AMOUNT PAID BY PLAN	AMOUNT TO BE PAID PER CONTRACT	OVER PAID	UNDER PAID
1009101502	$1,426.30	$1,596.30	-	$170.00
678062602	$572.00	$572.80	-	$0.80

CLAIM NO.	AMOUNT PAID BY PLAN	AMOUNT TO BE PAID PER CONTRACT	OVER PAID	UNDER PAID
5508051303	$788.00	$716.00	$72.00	-
4725060303	$156.00	$195.00	-	$39.00
4394100802	$743.75	$913.75	-	$170.00
6721090203	$80.00	$64.00	$16.00	-
4388emerg	$72.25	$63.75	$8.50	-
4388emerg-a	$382.50	$272.00	$110.50	-

The over/under payments were calculated using the specialist's UCR list maintained by the Plan.

The Plan was required to submit a Corrective Action Plan ("CAP") that identifies all claims paid since 2001, which have not been paid correctly. Furthermore, the Plan was required to submit evidence that the underpayments including interest and penalty, if applicable, were paid to the providers. The Plan was reminded that recoveries of any overpayments should be made in accordance with Rule 1300.71.

The CAP was to include the policies and procedures implemented to ensure that all claims payments will be checked against contracted prices to ensure accuracy. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that it has hired a specialist provider relations person to re-contract and contract new specialist providers over the next 12 to 18 months. This position will be responsible for completely revising the specialist files to insure that the Plan has the most currently contracted fee on file for the providers. A combination of the claims clerk and the provider relations staff will insure that claims payments will be checked against contracted prices to insure accuracy. In addition, the Plan has obtained the most recent fee schedules for the most frequently used specialist providers. The Plan identified the COO and Dental Director as the management positions responsible for overseeing the corrective action.

The Department finds that the compliance efforts by the Plan are not fully responsive to the deficiency cited and the corrective actions required by the Department. The Plan is required to submit evidence with its response to this Final Report that the underpayments including interest and penalty, if applicable, were paid for all claims identified.

C. ENROLLMENT REPORTING/PAYMENT OF ASSESSMENT FEE

Section 1356 (b) requires licensed health care service plans to report their enrollment on an annual basis and to pay an assessment to the Department based on the number of enrollees.

Rule 1300.84.06(b) sets forth the requirements for the supplemental information that is to accompany the quarterly financial statement filings.

The Plan failed to report Medi-Cal dental enrollees separately, under "Report #4: Enrollment and Utilization Table", in reports submitted to the Department until the quarterly report dated November 30, 2003. Instead, the Plan had routinely included Medi-Cal dental enrollees with the Plan's other enrollees.

The Plan was required to correct and restate the enrollment reported to the Department in the quarterly filings beginning with the August 31, 2002 report, specifically the cumulative Enrollees. In addition, the Plan was required to state the policies and procedures implemented to correct the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan responded that it will correct and restate the enrollment reported to the Department in the quarterly filings beginning with the August 31, 2002 report, including the cumulative Enrollees, by July 15th 2004. The Plan stated that it has a current checklist, previously submitted in the last financial audit response, for the preparation of the financial statements. The Plan stated it will include a description in the checklist of the deficiency and the required instruction on the correct reporting of the information. The Plan's officers, controller, and CPA were identified as the responsible individuals for implementation and continued monitoring and compliance.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

D. FINANCIAL STATEMENT PRESENTATION

Rule 1300.84.2 sets forth the requirements for the filing of quarterly financial statements with the Department. The Rule states that the quarterly financial statements (which need not be certified) are to be prepared in accordance with generally accepted accounting principles and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384 (c), unless the plan receives approval from the Director to vary from that basis and the variance is adequately noted in its report under this Section. This Rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the quarterly financial statement filings.

The Plan failed to correctly report the following:

- Medi-Cal income and expense items separately on income statements submitted to the Department prior to February 28, 2003. In addition, the Plan did not correctly report Medi-Cal income and expense items separately on income statements submitted to the Department for quarter ending August 31, 2003.

- Marketing expenses separately in its November 30, 2003 financial report to the Department or in its prior periods financial reports to the Department.

- The TNE calculation included with the Plan's November 30, 2003 financial report was incorrect. The Plan deducted $155,000 for receivables from shareholders instead of deducting the correct amount of $158,750.

The Plan was required to correct and restate the income and expenses as reported to the Department in the quarterly filings beginning with the November 30, 2001. The restated filings should also report the Plan's marketing expenses as a separate line item. Also the Plan should correct and restate the calculation of TNE in its November 30, 2003 filing.

The Plan was required to state the revised policy and procedures implemented to resolve the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan responded that it will correct and restate the income and expenses as reported to the Department in the quarterly filings beginning with the November 30, 2001. The restated filings will also report the Plan's marketing expenses as a separate line item. Also the Plan stated it will correct and restate the calculation of TNE in its November 30,2003 filing. All the stated corrections will be filed with the Department by July 15th, 2004. The Plan responded that it has a current checklist, previously submitted in the last financial audit response, for the preparation of the financial statements. The Plan will include a description, in the checklist, of the deficiency and the required instruction on the correct reporting of the information. The Plan's officers, controller, and CPA were identified as the responsible individuals for implementation and continued monitoring and compliance.

The Department finds that the compliance efforts by the Plan are responsive to the deficiencies cited and the corrective actions required.

E. BOOKS AND RECORDS

Rule 1300.85 requires every Plan to maintain books and records on a current basis and requires the retention of specific records. Section 1385 requires that each Plan keep and maintain current such books of account and other records as the Director may by rule require for the purpose of this chapter.

Rule 1300.85.1 requires every plan to preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan, the books of account and other records required under the provisions of, and for the purposes of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after the request.

Our examination disclosed the following:

- The Plan generates accounting journal entries and records them to the accounting system without proper explanation or documentation. (Refer to Section V- Internal Control).

- The Plan does not reconcile bank accounts correctly. (Refer to Section V- Internal Control).

- The Plan uses a chart of accounts with no number assigned to each account. The results are duplicate accounts with minor variations in the name. There is no control over adding new accounts, resulting in numerous posting errors.

The Plan was required to state the revised policy and procedures implemented to resolve the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan's responded as follows:

- *As of March 1st 2004, the Plan has created a Journal entry log that documents the journal entry by number, unique to the person posting the entry, and a description of the entry.*

- *After instruction and explanation by the Department, the Plan has instructed the accounting staff in the correct procedures in reconciliation of the bank accounts. The Plan's officers will review the deficient areas on a monthly basis and the Plan's CPA will review the reconciliations on a quarterly basis.*

- *The Plan has revised its Chart of Accounts and has assigned numbers to each of them. A copy of the new Chart of accounts was included with the Plan's response.*

The Department finds that the compliance efforts by the Plan are responsive to the deficiencies cited and the corrective actions required.

F. PROVIDER COMPENSATION

Section 1375.1 requires every licensed plan to demonstrate that it has a fiscally sound operation and adequate provision against the risk of insolvency. Rule 1300.75.1 requires that every plan demonstrate fiscal soundness and assumption of full financial risk. "In passing upon a plan's showing pursuant to this section, the Director will consider all relevant factors, including but not limited to: (1) The method of compensating providers and the terms of provider contracts, especially as to the obligations of providers to subscribers and enrollees in the event of plan insolvency."

The Plan's capitation analysis sent with the capitation check paid to the provider does not clearly disclose the plan level being paid for each enrollee assigned to the provider. The Plan was required to state the corrective action taken to resolve this issue. The Plan was also required to state the management position responsible for compliance.

The Plan responded that whenever it incorporates a new benefit schedule into the Plan's line of business that is not disclosed in the contract, it will notify those providers who will be accepting the benefit schedules and will include a copy of this addendum in the provider's file as verification.

The Plan stated that it did provide, to the Department's auditors at the time of the audit, documentation supporting breakdowns of capitation fees paid to providers by dental product that supported payments made to individual providers. However, the Plan has a few unique plan schedules that were not included in the schedule because of their limited use and area exclusiveness.

With respect to the capitation analysis sent with the capitation checks, the Plan responded that it is reviewing this process for possible solutions. The disclosures of variations in the capitation payments

are a result of the Plan's last financial audit by the Department and the corrective action that was implemented. The Plan stated that it is looking for a cost effective way to modify its Management Information System to accommodate the Departments request without incurring substantial software costs in the tens of thousands of dollars. The Plan indicated that it may have to change to a new MIS system all together to correct this deficiency. Initial estimates for a complete revision, done by the internal staff, of the tables and database structures could take between 6 to 9 months and could result in the plan going from 40 different capitation structures to well over 500 in order to provide the disclosure the Department requests. It is not known if the current database structures can withstand such a substantial increase in table complexity and variable calculation without complete MIS system failure or malfunction.

The Plan has asks the Department for more time to create an internal focus group to devise a cost effective way to revise its capitation system. This group will need to meet with the current software programmers, outside software vendors, and have internal discussions on possible scenarios to revise its systems.

The Department acknowledges the Plan's request for additional time to address this issue. However, the Plan is requested to submit a timeline detailing the specific steps it will be taking with its response to this Final Report.

SECTION VI. INTERNAL CONTROL

Section 1384, 1345 (s), and Rule 1300.45 (q) include requirements for filing financial statements in accordance with generally accepted accounting principles ("GAAP") and other authoritative pronouncements of the accounting profession.

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

The following deficiencies were noted during our examination:

- The Plan has failed to prepare bank reconciliation in a proper manner, and does not reconcile the bank balance to the general ledger cash balances. Reconciling items are not researched and corrected in timely manner. The reconciliation includes items dating back to 2002.

- The Plan has failed to prepare proper explanations and documentation for accounting journal entries prior to recording the entries in the accounting system.

- The Plan failed to keep and/or maintain a copy of the most recent specialist medical provider's UCR list. This resulted in overpayments and underpayments to the specialist providers.

- The Plan had various errors in recording cash transactions. These errors included duplicate entries, journal entries posted to the wrong bank account, unresolved old outstanding reconciling items, and the failure to move liabilities from a closed bank account to an open bank account. The Plan failed to correct these mistakes in bank accounts in a timely manner. However, these items were subsequently corrected by the Plan during the examination.

- The Plan failed to promulgate and implement a policy to properly deal with stale dated outstanding checks. The policy does not require that old outstanding checks should be reclassified as a liability, until reviewed and properly resolved, or escheated to the State Controller's Office.

The Plan was required to state the policies and procedures implemented to correct the above deficiencies, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan's responded as follows:

- *A work sheet to reconcile the bank balance to the general ledger was provided to the Department's auditors during the audit. As of March 1, 2004, the Plan used this form in its routine preparation of bank reconciliation. After instruction and explanation by the Department, the Plan has instructed the accounting staff in the correct procedures in reconciliation of the bank accounts. The Plan's officers will review the deficient areas on a monthly basis and the Plan's CPA will review the reconciliations on a quarterly basis.*

- *As of March 1st 2004, the Plan has created a Journal entry log that documents the journal entry by number, unique to the person posting the entry, and a description of the entry.*

- *The Plan addressed the correction of this deficiency in the Plan's CAP for Claims Management.*

- *The Plan feels that some of these errors are a result of the Plan's growth and the learning curve in the accounting staff to understand and adopt newer technologies. Once the Plan was informed of the error they were corrected immediately. The monitoring and continued compliance issues, as well as persons responsible for oversight are described in the Plan's response to Section V, item E.*

- *The Plan requests additional time to revise this policy due to the voluminous amount of paper work that needs to be re-filed to the Department and the current contiguous projects going on with the Plan's CPA and the changes to the financial staff. The Plan will submit a policy by June 15, 2004 to completely revise and implement a policy to correctly deal with stale dated outstanding checks. This policy will also reclassify the old*

outstanding checks as a liability, until reviewed and properly resolved or escheated to the State Controller's Office.

The Department acknowledges the Plan's request for additional time to address the issue regarding stale dated outstanding checks. Therefore, the Plan is requested to submit its revised policy to the Department with its response to this Final Report.

SECTION VII. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required to this Section.